Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged			
		Disabled (Physical)			
		Disabled (Other)			
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability	0		
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

To be eligible for the ID waiver, an individual must have a diagnosis of an intellectual disability. The diagnosis shall be made by a person who is a psychologist or psychiatrist, who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. A diagnosis of an intellectual disability shall be made in accordance with the mental retardation criteria provided in the Diagnosis and Statistical Manual of Mental Disorders, Fourth edition, published by the American Psychiatrist Association.

Iowa has developed rules, not yet promulgated in the Iowa Administrative Code (IAC), to change the diagnosis criteria for the intellectual disability waiver from mental retardation to intellectual disability. The diagnosis will be made in accordance with the Diagnosis and Statistical Manual of Mental Disorders, fifth edition, (DSM-V) published by the American Psychiatrist Association. It is anticipated that the rule change will be included in the IAC on or before July 1, 2015.

Prior to this ID waiver renewal application, an individual applying for the residential based supported community Living service within the ID waiver could have a diagnosis of an intellectual disability OR a diagnosis of a mental disability equivalent to Mental Retardation as determined by a psychologist or psychiatrist. This service criterion has been part of the ID waiver since RBSCL was added to the ID waiver. No individual has used these eligibility criteria to access RBSCL services. This criterion is in conflict with CMS rules that prohibit eligibility of a waiver or service within a waiver program to a subsection of the waiver population as a whole. The state of Iowa will begin the rule change process to remove the criteria for the ID waiver program and will not allow this criteria to be used

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to

legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	14203
Year 2	14203
Year 3	14203
Year 4	14203
Year 5	14203

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

The State does not limit the number of participants that it serves at any point in time during a waiver year.

The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	12912
Year 2	12912
Year 3	12912
Year 4	12912
Year 5	12912

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

Not applicable. The state does not reserve capacity.

The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes	
Residential Based Supported Community Living	
ICF/ID (including MFP) transition	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Residential Based Supported Community Living

Purpose *(describe):*

Within the ID waiver program, services may be provided to children outside of the parental home. This program is called the Residential Based Supported Community Living (RB-SCL) services. Services are provided in licensed Residential Care Facilities for Children with Intellectual Disabilities (RCF/ID) that are licensed by the Iowa Department of Inspections and Appeals. The 72 slots are separate from the 100 reserved capacity slots for children. The RB-SCL program is designed for children under the age of 18 that receive services outside of the family home in a licensed residential care facility for children with Intellectual Disabilities (RCF/ID).

Describe how the amount of reserved capacity was determined:

Seventy-two (72) slots have been reserved for use in the RBSCL program based on fiscal analysis and services needs

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	72
Year 2	72
Year 3	72
Year 4	72
Year 5	72

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

ICF/ID (including MFP) transition

Purpose *(describe):*

The state reserves 125 slots each year (see numbers below) for use by members living in an ICF/ID who choose to access services in the ID waiver program. This is an increase of 25 slots annually to accommodate members moving from ICF/ID's with assistance from the Money Follows the Person (MFP) grant currently operating in Iowa. Slots are available for use by any eligible person for the ID waiver program that currently resides in an ICF/ID, has lived there for at least six months, and chooses the ID waiver program over institutional services.

Once the reserved capacity slot is accessed by a member leaving an institution, the slot is not available to anyone else during the current waiver year. The ICF/ID reserved capacity slot will revert back into the pool of available ICF/ID reserved capacity slots at the end of the ID waiver year, ending June 30 each year. This will assure that no more than 125 slots are used in any given year and will assure that 125 slots are available annually. Once the member gets on the ID waiver, they are included in the annual member count towards the total numbers served and unduplicated member count identified in Appendix B-3 sections a. & b.

Describe how the amount of reserved capacity was determined:

The 125 slots were based on anticipated movement of consumers moving from ICF's/ID to community based settings. This is an increase of 25 slots annually from the previous waiver approval. During the next five years, it is anticipated that the additional slots may be needed to accommodate members moving to the community from ICF's/ID due to the Money Follows the Person (MFP) grant. The additional slots are being requested during the years that the MFP grant is in place.

The MFP grant allows members living within an ICF/ID to move to community based services funded through the ID waiver. It is anticipated that during the five years of the MFP grant that 589 member will move from ICF's/MR to the ID waiver program. The MFP grant funds the first 365 days of services provided in the community. After the first year, the member will apply for and receive funding through the ID waiver. The ICF/ID reserved capacity slots are intended to assure that members living in ICF's/ID have slots available to make the transition to the community and continued funding through the ID waiver program after MFP funding ends.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	125
Year 2	125
Year 3	125
Year 4	125
Year 5	125

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The state has established Iowa Administrative Code rules and developed administrative procedures to managed one statewide waiting list for the ID waiver program. When the number of members accessing the ID waiver equals the amount of funding slots approved by CMS in the approved waiver application, all new applicants shall be placed on a statewide waiting list. The waiting list shall be managed by the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME), the entity that is the Administrative Authority for the HCBS waiver programs. Applicants shall be placed on the waiting list based on their assessed priority of need. Applicants shall be assessed and placed into three levels of need: emergency, urgent, or non-urgent.

Emergency criteria shall include:
1. Caregiver death or incapacity to provide care and no other caregivers are available to provide needed supports.
2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available
3. The applicant is permanently living in homeless shelter as identified by living in a shelter for at least 30 days and there are no plans to move to another living arrangements identified.
4. There is founded abuse or neglect by a caregiver or by others within the home of the caregiver and the applicant must move out of the home.
5. The applicant cannot meet basic health and safety needs without immediate supports

Urgent criteria shall include:
1. The caregiver will need support within 60 days in order for the individual to remain living in the current situation
2. The caregiver is unable to continue to provide care within next 60 days.
3. The primary caregiver is 55 years of age or older and has a chronic or long term physical or psychological condition that limits the ability to provide care.
4. The applicant is living in temporary housing with plans to move within 31 - 120 days
5. The applicant is losing permanent housing with plans to move within 31 - 120 days
6. The caregiver will be unable to be employed if services are not available
7. Potential risk of abuse or neglect by caregiver or by others within the home of the caregiver
8. The applicants has behaviors that puts self at risk
9. The applicants has behaviors that put others at risk
10. The applicant is at risk of facility placement when needs could be met through community based services.

Non-urgent criteria include:

1. The caregiver is identifying that there is no present need for the applicant to move/relocate from the current situation due to the abilities of the caregiver to provide care.
2. There is no present need for new housing situation
3. The applicant wants to move from family home to own home.
4. There is no risk of abuse or neglect identified
5. There is no at risk behaviors identified
6. The current living arrangement is appropriate to meet needs.

An applicant shall be placed on the priority wait list based on the outcome of an assessment completed by Department personnel. The assessment shall determine the priority need of the applicant that will determine either immediate access to a funding slot or shall determine placement and location (position) on the state wide waiting list. All applicants on a waiting list maintained by the state or the individual county on December 31, 2010 shall receive an assessment to determine a priority score. All new applicants on January 1, 2011 and beyond shall have received and assessment to determine a priority score.

The scoring of the assessment completed by Iowa Medicaid Enterprise (IME) or Department personnel and the subsequent placement is as follows:

Emergency level of need scoring.

An applicant shall have access to a funding slot if the assessment finds that the applicant meets a minimum of one of the five emergency level criteria listed. When it is determined that the applicant meets any of the emergency criteria, has no other supports and services available to meet their basic needs, and have needs that can be met through the ID waivers, the member shall have immediate access to a funding slot. There are no points given to an applicant in the emergency level of need.

Urgent level of need scoring.

An applicant shall receive one point for each of the criteria that the member is assessed to meet under the urgent level of need. At the completion of the assessment a total score is established for the applicant and their name is placed at the top of wait list based on the total score. The highest score will be given the first position on the waiting list.

Non-urgent level of need scoring.

There is no point value assigned to the non-urgent criteria. Members that only have needs within the non-urgent level shall be placed on the priority wait list based on the date of application. All applicants that have an urgent level of

need score shall be placed on the waiting list prior to those applicant with non-urgent needs.

Scoring Criteria:

An applicant may score criteria in only one category (e.g., cannot meet both emergency and urgent criteria in the homeless category)
An applicant may score criteria in different categories (i.e., may meet urgent criteria in loss of caregiver and non-urgent in homeless.)
An applicant may meet more than one criteria within the category (i.e., meet both criteria in at risk behavior)
An applicant may only score in criteria areas that are applicable based on documented assessed need.

Management of the waiting list.

After the applicant has been assessed and placed on the waiting list they shall remain on the list until a funding slot has been assigned to them for use or they choose to withdraw from the list. When a funding slot becomes available, the applicant at the top of the list shall be given the funding slot. New applicants shall be assessed and placed on the list based on the assigned score for the assessment. New applicants may be placed on the waiting list in a higher position than those currently on the waiting based on their priority need score.

Placement on list.

Applicants that meet the emergency criteria will be placed at the top of the list and will receive a funding slot immediately.
Placement on the prioritized waiting list is based on a total score of prioritized need.
Each new applicant will be assessed by Department personnel.
Total score will determine placement on the waiting list. When one or more applicants have the same score, available slots will be based on:

1. The date of application for services
2. Length of time waiting for a prioritized slot
3. Date of birth, older applicants will have a higher priority

Movement on waiting list

As a funding slot becomes available, the applicant at the top list shall be given the slot. The applicant will be contacted by the DHS Income Maintenance (IM) worker to begin the process to determine eligibility and level of care (LOC) for enrollment in the ID waiver. The process will continue until the applicant becomes an enrolled member in the ID waiver or is determined to be ineligible or terminates from the process. An applicant must meet all eligibility requirements of the ID waiver to access a funding slot.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:

   §1634 State

   SSI Criteria State

   209(b) State

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:

   No

Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional State supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

- Parents and other caretaker relatives specified at 435.110
- Pregnant women specified at 435.116
- Children specified at 435.118

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*

Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

The following standard included under the State plan

Select one:

SSI standard
Optional State supplement standard
Medically needy income standard
The special income level for institutionalized persons

(*select one*):

300% of the SSI Federal Benefit Rate (FBR)
A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

300% of the SSI benefit and for members who have a medical assistance income trust (MIller trust) and additional $10.00 (or higher if court ordered) to pay for administrative fees.

Other

Specify:

ii. Allowance for the spouse only (*select one*):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (*select one*):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

300% of the SSI benefit and for consumers who have a medical assistance income trust (Miller Trust) an additional $10 (or higher if court ordered) to pay for the administration fees.

Other

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

At least one unit of HCBS waiver services must be accessed every calendar quarter by the ID Waiver member.
As part of the ID waiver service, targeted case management is required for each member. Targeted case managers are required to make monthly contacts, either face to face or telephonic, regarding each member in order to establish access to services and to ensure the authorized services are provided as outlined in the member's service plan to ensure the member's health, safety and welfare. Targeted case managers are additionally required to make face-to-face contact with the member once per quarter.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

The Iowa Medicaid Enterprise Medical Services Unit shall be responsible for determining the level of care based on the completed assessment tool and supporting documentation from the medical professional while supplemental information may also come from the service worker, applicant, or other appropriate professional.

Other

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

IME Medical Services requires that the individuals who determine the level of care are licensed registered nurses.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

IME Medical Services uses the Case Management Comprehensive Assessment Tool in conjunctions with the Long Term Care ICF/ID criteria, which reviews the entire body system to specify a level of care. The Long Term Care ICF/ID criteria and the Case Management Comprehensive Assessment Tool looks at the following criteria: Ambulation/mobility, musculo-skelatal-disability/paralysis, activities of daily living, elimination, eating skills, sensorimotor, intellectual/vocational, social, maladaptive behaviors, heath care, and psycho-social.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The Long Term Care ICF/ID criteria are the same criteria used to evaluate both waiver and institutional level of care. The Case Management Comprehensive Assessment Tool currently used for ID waiver services identifies care needs in the home setting that are not the same for the institutional setting. The results of the assessment are used to develop the plan of care. Because the same criteria is used for both institutional care and waiver services, the outcome is reliable, valid and fully comparable.

Effective July 1, 2014, the ID waiver program will begin to use the Supports Intensity Scale (SIS) assessment with members accessing the ID waiver. The SIS is a unique, scientific assessment tool specifically designed to measure the level of practical supports required by people with intellectual disabilities to lead normal, independent, and quality lives in society. The use of the SIS with ID waiver members will be transitioned in over a two year time period with approximately 1/2 of the adult ID wavier population being assessed using the SIS each year. The SIS must be completed for each member once in a three year time period. During the two "off" years, a core standardized assessment (CSA) tool will be used for the annual CSR. A request for proposal has been issued to establish a contract to implement the use of the SIS for the ID waiver. A new CSA, to be determined by the new contractor in the future, will be used for the annual CSR. The SIS is for use with adults with intellectual disabilities. A SIS for children is being piloted and it is anticipated it will be ready for use in 2015. Until such time the new CSA will be used for the annual CSR for children.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The use of the SIS with ID waiver members will be transitioned in over a two year time period with 1/2 of the ID wavier population being assessed using the SIS each year. The SIS must be completed for each member once in a three year time period. During the two "off" years, a core standardized assessment (CSA) tool will be used for the annual CSR. A new CSA, to be determined by the new contractor in the future, will be used for the annual CSR. The SIS is for use with adults with intellectual disabilities. A SIS for children is being piloted and it is anticipated it will be ready for use by 2015. Until such time the new CSA will be used for the annual CSR for children.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

Every three months

Every six months

Every twelve months

Other schedule
Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The reevaluations are tracked in the Iowa Department of Human Services Individualized Services Information System (ISIS). A reminder is sent out to the person responsible for the evaluation 60 days before the reevaluation is due. A continued stay review report is available through ISIS to track reevaluations that are overdue and is monitored by Medical Services and the Bureau of Long Term Care with the Iowa Medicaid Enterprise. The LOC contractor reports monthly, quarterly and annually on the timeliness of the initial and annual reevaluations completed.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All level of care documents are faxed into the Iowa Medicaid Enterprise and placed in OnBase. OnBase is the system that stores documents electronically and establishes workflow.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LC-1a: Number and percent of members that have a valid level of care assessment completed prior to receipt of waiver services. Numerator: # of valid level of care assessments made prior to receipt of waiver services Denominator: # of level of care assessments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The data informing this performance measure is pulled from ISIS. Reports are pulled and data is inductively analyzed at a 100% level. Conclusions are made based on the data that is pulled.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =
Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LC-1b: Number and percent of level of care determinations completed within 12 months of their initial evaluation or last annual evaluation. Numerator: # of level of care assessments made within 12 months of previous assessment Denominator: # of level of care re-assessments due.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The data informing this performance measure is ISIS data. Reports are pulled and data is inductively analyzed at a 100% level. Conclusions are made based on the data that is pulled.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval =

Other Specify:	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LC-1c: Number and percent of initial level of care determinations made for which criteria were accurately and appropriately applied for the determination.

Numerator: # of accurate initial level of care determinations Denominator: # of initial level of care determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Medical Services Unit performs internal quality reviews on the level of care determinations that have been made. Data is reported on a quarterly basis and conclusions are reached inductively.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 5%
Other Specify: Contracted entity	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Continuously and Ongoing
	Other Specify:

Performance Measure:
LC-2c: Number and percent of reevaluation of level of care determinations for which criteria were accurately and appropriately applied for the determination.
Numerator = # of accurate level of care determinations at reevaluation
Denominator = # of level of care determinations at reevaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Medical Services Unit performs internal quality reviews on the level of care determinations that have been made. Data is reported on a quarterly basis and conclusions are reached inductively.

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
State Medicaid Agency	**Weekly**	**100% Review**
Operating Agency	**Monthly**	**Less than 100% Review**
Sub-State Entity	**Quarterly**	**Representative Sample** Confidence Interval = 5%
Other Specify: Contracted entity	**Annually**	**Stratified** Describe Group:
	Continuously and Ongoing	**Other** Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify:	**Annually**
	Continuously and Ongoing
	Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Data is collected quarterly through reports generated on ISIS data. Data is inductively analyzed at a 100% level. This data is monitored for trends in procedural standards from an individual and systems perspective.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state's Individualized Services Information System (ISIS) is programmed to provide warnings when service plans are attempted to be entered prior to an initial or annual level of care determination. The programming was also intended to prevent service plans from being developed prior to the level of care determinations but it has been identified that there is a cushion of time (60 days) in which the case manager may enter in service plan revisions/extensions beyond the level of care due date. Action is being taken to investigate and remediate this issue.
The state's Medical Services Unit performs internal quality reviews of initial and annual level of care determinations to ensure that the proper criteria are applied. In instances when it is discovered that this has not occurred the unit recommends that the service worker take steps to initiate a new level of care determination through communication with the member and physician.
General methods for problem correction at a systemic level include informational letters, provider trainings, collaboration with stakeholders and changes in policy.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
State Medicaid Agency	**Weekly**
Operating Agency	**Monthly**
Sub-State Entity	**Quarterly**
Other Specify: Contracted Entity	**Annually**
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the enrollment process, one of the required milestones in the Individual Services Information System (ISIS) states the Case manager/service worker is to explain to the member and to the member's legal representative the choice between HCBS waiver and institutional services. The freedom of choice is documented by both the income maintenance worker and the case manager and is placed in the consumer's file.

There are waiver informational brochures available to share with members and their parents/guardians. Brochures are available at each of the DHS county offices where the income maintenance workers are located. Information is also available on the IME website. The brochures include information on eligibility, service descriptions, and the application process. Once a member begins the enrollment process and has a services worker/case manager assigned, a more detailed review of services and providers that are available in the area occurs as part of the planning process for developing a member's plan of care.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the member's choice are maintained at the local Department of Human Services Income Maintenance Worker office. In addition, Case Managers keep copies of the member's choices.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Iowa Department of Human Services adopts the policy as set forth in Title VI of the Civil Rights Act prohibiting national origin discrimination as it affects people with limited English proficiency. The Department shall provide for communication with people with limited English proficiency, including current and prospective members, family members, and consumers to ensure an equal opportunity to benefit from services. The Department has developed policies and procedures to ensure meaningful access for people with limited English proficiency. These include procedures to:

1. Identify the points of contact where language assistance is needed.
2. Identify translation and interpretation resources, including their location and their availability.
3. Arrange to have these resources available in a timely manner.
4. Determine the written materials and vital documents to be translated, based on the populations with limited English proficiency and ensure their transition.
5. Determine effective means for notifying people with limited English proficiency of translation services available at no cost.
6. Train Department staff on limited English proficiency requirements and ensure their ability to carry them out, and monitor the application of these policies on at least an annual basis to ensure ongoing meaningful access to service.

All applications and informational handouts are printed in Spanish. In addition, the contract with IME Member Services requires a bilingual staff person be available to answer all telephone calls, emails and written inquiries. Member Services also works with interpreters if another language is needed. All local Department of Human Services Offices have access to a translator if a bilingual staff person is not available. The Department includes this policy as part of their Policy on Nondiscrimination that can be found in the Iowa Department of Human Services Title 1 General Departmental Procedures in the Department Employee Manual.